ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
1740 W. ADAMS ST., SUITE 4600, PHOENIX, ARIZONA 85007
PHONE (602) 364-1PET (1738) FAX (602) 364-1039
VETBOARD.AZ.GOV

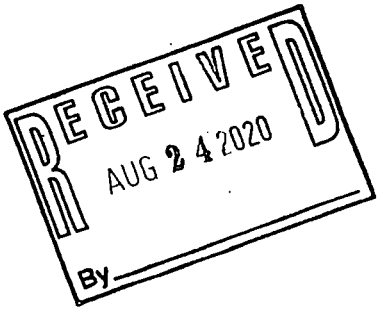
COMPLAINT INVESTIGATION FORM

If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian

PLEASE PRINT OR TYPE

FOR OFFICE USE ONLY

Date Received: Aug 24, 2020 Case Number: 21-16



A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:

Name of Veterinarian/CVT: Megan M. Schalble

Premise Name: Southwest Veterinary Surgical Service, PC

Premise Address: 22595 N Scottsdale Rd Ste 120

City: Scottsdale State: AZ Zip Code: 85255

Telephone: (855) 274-4798

B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT*:

Name: Cheryl Scott

Address: [redacted]

City: [redacted] State: [redacted] Zip Code: [redacted]

Home Telephone: [redacted] Cell Telephone: [redacted]

**STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.*

C. **PATIENT INFORMATION (1):**

Name: Tucker Scott

Breed/Species: Shepherd Mix

Age: 1 year 8 mos Sex: Neutered Male Color: Black/Tan

PATIENT INFORMATION (2):

Name: n/a

Breed/Species: _____

Age: _____ Sex: _____ Color: _____

D. **VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:**

Please provide the name, address and phone number for each veterinarian.

Megan M. Schaible, DVM, DACVS
22595 N Scottsdale Rd Ste 120
Scottsdale, AZ 85255

E. **WITNESS INFORMATION:**

Please provide the name, address and phone number of each witness that has direct knowledge regarding this case.

2nd Opinion and Revision Surgery
Ross Lirtzman, DVM, DACVS
Arizona Canine Orthopedics & Sports Medicine
[redacted]

Attestation of Person Requesting Investigation

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: _____

Date: 8/24/2022

F. ALLEGATIONS and/or CONCERNS:
Please provide all information that you feel is relevant to the complaint. This portion must be either typewritten or clearly printed in ink.

On 6/11/20 we brought or dog, Tucker, to Dr. Megan Schaible to have a right tibial plateau leveling osteotomy with a cranial wedge performed. The cost was $5,904.45, and the surgery was paid in full upon completion. After surgery was completed, I did request to see films of procedure, but was told by the tech that I could request it the next time as well. So, I decided I would just collect the films at Tucker's 8 week follow up.

We limited Tucker to minimal ambulation for all 8 weeks. However, on 6/26/20, when returning home from a trip for a weekend, Tucker jumped out of our stopped SUV. The height was about 3-4 feet. Immediately after, Tucker continued to weight bear bilaterally, but I still phoned the surgeon on 6/29/20 (the next business day for them). I spoke with the front office person and explained the situation. I requested films to make sure the fixation held. I was called back and was told "As long as he is still weight bearing, we have no concerns at all. Just continue with more pain meds. If he stops putting weight on it, then we would be concerned, so you would only bring him in then"

Tucker continued to heal and never had any episodes of non-weightbearing or increased limping for the next 4 weeks. At exactly 8 weeks, 8/6/20, we brought Tucker back to Dr. Schaible, where I requested to see the films. At this time, Dr. Schaible explained that the surgery had failed and he needed a revision. She stated that "something must have happened". I discussed the one episode of jumping from the SUV and told her that I called and requested films, but was told not to worry. I also stated that while he did limp a little more from that jump- he never stopped weight bearing and continued to progress. I also discussed that for the last week (week 7), we had been letting him go outside (off leash) to urinate. He was still supervised and there was no running/ jumping observed for each episode. Dr. Schaible told me that if I would have brought Tucker in at the time of the jump "maybe this would have been prevented". When I told her what I was told when I called she stated "That's not exactly what we said, I will talk to the front office to discuss how to state things." After providing me a quote for a the revision surgery, and telling me to wait 3 weeks to perform the revision "for more bone healing" she left the clinic room.

I asked if I could take a picture of the films they were showing me and was told that I could. I sent those films to my husband as soon as I got there, however he as performing surgery at the time and saw them only after Dr. Schaible left. Since my husband, Ryan, does have knowledge of surgical fixation (albeit in humans, of course), he felt that the fixation choice for a double osteotomy was inadequate and it should have been a biplaner plating or further robust fixation with screws instead of a single K-wire. He told me to ask if she felt one K-wire was appropriate for the surgical intervention performed. Dr. Schaible never returned to the room, but I did ask the tech to relay the question. I was told that Dr. Schaible was seeing other patients and it could be up to 2 hours before she had time to talk to me again. I told the tech that I was happy to wait in the office because the answer was important to me. Dr. Schaible never returned to talk with me (in the 5 hours I was there), however, she did call my husband and talk with him, while I was sitting in her office. In the discussion with my husband, she defended her choice, but her reasoning did not make sense. After the conversation, we were told that we would be provided a new quote for the revision surgery since we were so upset with the fixation. We received a new quote a few days later that still had Dr. Schaible billing us for her surgical services. With return communications,

they dropped the quote a second time. However, our concern started to become whether we could trust her to perform a revision surgery correctly based on her poor initial fixation choice

On 8/21/20 we decided to get a second opinion from Dr. Ross Lirtzman at Arizona Canine Orthopedics and Sports Medicine. Our reservations were confirmed. Dr. Lirtzman stated that the surgical choice of fixation "wasn't what he would have done as he would have made it more robust to prevent failure". Additionally, he stated he was unsure why Dr. Schaible would want to wait an additional 3 weeks as the type of revision surgery that Tucker needs is emergent to prevent further disruption and tissue/bone damage. Since we now no longer have any faith in Dr. Schaible, we have decided to get a revision surgery performed by Dr. Lirtzman. Unfortunately, we again, have to pay for the same surgery in full (a minimum of $5,767.50-$7,246.90). At this time, we are requesting the Arizona Veterinary board to look into our case as we feel that the fixation technique chosen by Dr. Schaible set Tucker up for failure even before he left her surgical suite. Additionally, we would like to be reimbursed for the full cost of surgery ($5,904.45) since it failed so poorly due to her choice of fixation.

Please let me know if you have any further questions. We are currently in the process of setting up the revision surgery with Dr. Lirtzman, and starting Tuckers recovery process all over again.

September 9, 2020

Arizona State Veterinary Medical Board
1740 W. Adams St
Suite 4600
Phoenix, AZ 85007

Re: 21-16

To Whom It May Concern:

"Tucker", a 1.5-year-old neuter male shepherd mix weighing 75 pounds, owned by Dr. Ryan and Cheryl Scott, was referred to Southwest Veterinary Surgical Service (SVSS) on June 11, 2020. Based on his medical records, his clinical signs and initial evaluation for right hindlimb lameness on September 20, 2019, a diagnosis of a right cranial cruciate ligament rupture was confirmed by radiographs on October 1, 2019. The patient was treated with analgesics but surgical correction was not pursed at that time. Tucker was seen again by his primary veterinarian on June 6, 2020 (8 months later) for persistent right hindlimb lameness and additional confirmation of the diagnosis.

The owners scheduled a consultation with tentative surgery on June 11, 2020. Due to Covid-19 protocols, the owners were instructed at the time of making the appointment that they would need to call the front desk when they arrived and that they would have to remain outside the hospital. They were also advised that a technician would come to the vehicle to obtain a history, current mediations and bring the patient inside.

On June 11, 2020, Tucker presented to Southwest Veterinary Surgical Service for a consultation with me. Technician Lexi Burandt (LB) proceeded with our normal patient check-in procedures and Ms. Cheryl Scott was the only owner present for the appointment. Tucker was brought to our treatment area where I reviewed his history. A complete physical examination was performed and the major findings were a BCS 7/9, right hindlimb lameness with positive cranial tibial thrust and cranial drawer tests on the right stifle, and mild cranial drawer test on the left stifle.

Upon review of the patient's available radiographs both right and left tibia had higher than normal tibial plateau angle (TPA) and bilateral stifle effusion. Ms. Scott was contacted by phone to discuss the examination, previous diagnostics and surgical recommendations. We reviewed the cranial cruciate ligament (CCL) disease process and that Tucker had bilaterally an abnormal proximal tibia leading to a TPA in excess of 35 degrees. This important component was explained to Ms. Scott and discussed since patients with an excessive TPA do not obtain enough leveling from a standard tibial plateau leveling osteotomy (TPLO) and require additional planning, mathematical calculations and surgical procedures. We discussed that a cranial closing wedge osteotomy (CCWO) which requires two additional osteotomies would be necessary in addition to the standard TPLO osteotomy. We would then reduce both cuts in the bone and stabilize. I explained a standard 6-hole TPLO plate would be used in combination with several options including a second plate, pins and possibly cerclage wire. These decisions would be made during radiographic planning but more so at the time of surgery based on size of bone, location of osteotomies and weight of patient. We also discussed the strict postoperative exercise restrictions (at least 3 months with no running, jumping, or stairs and unleash at all times until radiographic healing was confirmed) and a handout was provided preoperatively. The po-

tential complications were discussed and emphasized due to the additional procedures required for Tucker. Complications can include infection, incisional complications, seroma formation, fractures of the bone, breakage of the implants, implant failure, latent meniscal tears, progressive osteoarthritis, implant removal and increased risk of complications occurring with TPLO/CCWO procedures. We also discussed my concern for early left cranial cruciate ligament instability and excessive TPA on that limb and that 50-60% of patients with CCL disease rupture the contralateral ligament. An itemized estimate, surgical consent forms and CPR code options were reviewed with Ms. Scott and she signed the form and consented to surgery.

Tucker was admitted to SVSS that day for preoperative bloodwork and right stifle radiographs. The bloodwork was within normal limits except a mild increased cholesterol and low amylase. The right stifle radiographs confirmed stifle effusion with cranial displacement of the tibia in relation to the femoral condyles and a TPA of 51 degrees. Radiographic planning was performed and the TPA was calculated to be 51 degrees. Via planning and intraoperative confirmation, the TPLO osteotomy was performed with a 24 mm radius TPLO blade and rotated 10.25 mm based on the predetermined TPLO chart. The CCWO was calculated to require a 20 degree (omega). The calculation Y=X(tan omega) was used to determine that the wedge width at the cranial tibial would be Y=10 mm and these osteotomies were made with a sagittal saw.

The procedure was performed as described in the surgery report with a mini-arthrotomy and decision to perform a meniscal release (cutting the caudal medial meniscotibial ligament) was made to decrease the potential risk of future meniscal tears. After reduction of the osteotomies a 0.062 mm k-wire was placed from cranial to caudal from the proximal tibial tuberosity into the proximocaudal tibial metaphysis. Then a 3.5 mm New Generation TPLO plate was placed with 1 locking and 2 non-locking cortical screws proximally and distally to the osteotomy site to stabilize the proximocaudal tibial metaphysis to the tibial diaphysis. The decision was made to place a second plate in additional to stabilize the tibial tuberosity to the tibial diaphysis. A 5-hole 2.7 mm locking acetabular plate, which I have used on other cases in the past, resulted in the plate and 1 screw hole extending off the bone cranially when assessed in several positions. Other available plates were assessed and a 2.0 mm 6-hole TWO plate was selected. Three 2.0 mm cortical screws were placed proximal and distal to the osteotomy. Elimination of cranial tibial thrust was confirmed intraoperatively. Postoperative radiographs were performed and a ~7-degree TPA confirmed, a modified Robert-Jones bandage was applied and the patient recovered uneventfully from anesthesia.

Initially, Aubrey Novotny (AN) contacted Ms. Scott at 2:31pm to give her a postoperative update that Tucker had recovered from anesthesia and she was also told that Dr. Schaible would contact her later to give additional details. I personally updated Ms. Scott at 4:03 pm and as documented in the records informed her that Tucker was doing well and that we corrected the TPA and placed 2 plates and a pin for stabilization. I also reiterated again that these patients have higher risk of complications due to the multiple bone cuts and that the exercise restriction and rehabilitation instructions were very important to follow.

Tucker was assessed by the third-year surgery resident, Emily French, DVM, the morning of June 12, 2020 and approved for discharge to the owners at 8:30 am. The discharge was performed by overnight technician Taylor Corinth (TC). Our standard discharge procedures were performed and detailed discharge instructions were reviewed verbally and provided to owner.

A follow-up phone call was performed the next open business day which was June 15, 2020 by technician AN. As documented in the records, Ms. Scott felt that Tucker was doing well, had no medical concerns but did inquire about having the staple removal at the primary veterinarian.

As a convenience to the owners, we do allow staples to be removed and the stifle to be assessed by either SVSS or the primary veterinarian.

On June 29, 2020 (19 days postoperatively) Ms. Scott spoke with Avery Santos (AS), a customer care representative, and described that Tucker was intermittently limping on the right (surgical) hindlimb after being allowed to jump from 3-4 feet out of their SUV. There is no documentation that the owner expressed concern about the left hindlimb (non-surgical limb) at this time. The technician AN was notified of this information and advised that since an acute event had occurred, the owner could consider continuing pain medications and monitor and if the lameness did not resolve, worsens or persisted intermittently, then the owner should contact SVSS to schedule a recheck examination. The owner asked for additional medications from a pharmacy, which were authorized.

No additional communication occurred with the owner until July 20, 2020 when the owner contact SVSS to schedule recheck radiographs for August 6, 2020 at 8:30 am. The appointment was confirmed on August 5th and during both of these communications with SVSS the owners did not report any other issues.

On August 6, 2020 (8-weeks postoperatively) Tucker presented to SVSS with Ms. Scott, and a reduced Covid-19 protocol was in place, which allowed one owner to accompany the patient into the hospital while wearing a mask. Tucker was initially taken to the treatment area by technician Carly Hulsey (CH) and Ms. Scott remained outside. Ms. Scott did express concerns that Tucker was not progressing as quickly as they had expected and that he had episodes of limping. The history taken by CH reflects that the owners were exercise restricting Tucker but had permitted the use of flights of stairs starting one week prior.

Tucker was examined and noted to have severe muscle atrophy on the right hindlimb, grade II/IV lameness right hindlimb and mild pain on palpation of the right hindlimb. The right TPLO radiographic imagines were performed and a complication was confirmed. The bone has fractured at the distal tibial tuberosity causing the bone to pull out of the 3 proximal 2.0 mm screws. All implants were intact and no loosening was noted. The tibial tuberosity showed radiographic bone healing to the TPLO osteotomy with no avulsion of this segment. The loss of reduction of the cranial portion of the CCWO lead to de-rotation of the proximal tibia and increased TPA back to 41 degrees.

CH asked Ms. Scott to come into the building and I personally, along with Amanda Schaff, DVM (rotating Blue Pearl intern) discussed my concerns and radiographic findings Ms. Scott. We reviewed both the postoperative and 8-week recheck radiographs. Ms. Scott took photos of the images and sent them to her husband Dr. Ryan Scott. I also offered to email the radiographs to them. I was very upfront with the owners about the complication and that I had even called another SVSS surgeon to review the images. We discussed my recommendation that the surgery be revised to deal with the complication and that both myself and the other surgeon suggest waiting 4-5 weeks to allow the TPLO osteotomy to continue to heal prior to removing the previous TPLO plate to make room for additional implants craniolateral and cranial surfaces of the bone. Currently, my plan would have been to remove the TPLO plate and screws, reduce the failed ostectomy site, placing a new plate more craniolateral (likely a left TPLO since it allows multiple screws in a narrow bone window, then leave the intact pin and place another diverging pin, a tension band from the proximal pins into the tibial diaphysis and another tension band from distal segment of the tibial tuberosity into the tibial diaphysis. We also discussed that they had not been doing the rehabilitation exercises or walk regiment because "they both work but that he was getting enough exercise since they allow off leash on their 2-acre property." I re-

minded her that Tucker was not supposed to be off leash until approved by the surgeon and that both the jump from the vehicle and the unrestricted activity could be the cause of the complication.

When everything was reviewed, Ms. Scott stated that "her husband wouldn't want to spend more money" and I let her know we would make an estimate with some discounts that I could approve as an associate veterinarian. That estimate was immediately provided to her and reviewed. We discussed the information in person and we also wrote a detailed discharge since both owners were not present.

CH informed me that Ms. Scott wanted me to speak with her husband Dr. Scott before she was willing to leave the hospital. We let her know that I would contact him as soon as possible but that there could be an extended wait due to my schedule. I contacted Dr. Scott as soon as my schedule allowed, this was around 11 am. His initial question was why did Tucker require the TPLO/CCWO and not a routine TPLO. This requirement was again reviewed, as it had been with his wife Ms. Scott at the first visit. I also again reviewed the biomechanics of the TPLO. Dr. Scott then asked why a cranial plate was not applied and I explained that we never plate the cranial tibial surface in dogs due to the narrow bone window anatomically. We did place a pin from the cranial to caudal tibia to prevent a tibial tuberosity avulsion and then the second plate to stabilize the second osteotomy more cranial (as far forward as bone allowed). We discussed what I anticipated for revision surgery and my reason for the delayed timing of that procedure. We discussed that various factors can lead to the complication seen and that there has to be some responsibility on their part with the noted issues occurring at home but we wanted to work with them to get Tucker the best outcome possible.

During our conversation, Dr. Scott stated that in his job (human doctor) he doesn't see the itemized invoice but it's our responsibility to "cut the fluff" and charge for the cost of items only. I let him know we were already having the medical director (another surgeon) and hospital manager review the case details and if additional discounts could be applied, as a courtesy, we would update them in 1-2 days. I asked if he wanted me to speak with Ms. Scott his wife again and he stated he would speak with her. CH informed me that when she checked in with Ms. Scott she wanted to wait until we have the revised estimate. I had customer service manager Leann Pritchard (LP) and CH as witness, discuss our plan to get the case reviewed and any additional discounts approved but that we needed 1-2 days since these individuals were off site and that we didn't want to have her continue to wait when no additional estimate would be available that day. We offered pain medication refills to the pharmacy or at SVSS and she declined. Ms. Scott left SVSS around 11:37 am based on the conversation documented by LP, so she was there for a total of 3 hours.

The case was reviewed and a revised estimate, that SVSS felt was fair due to the failure of the owners to comply with instructions, was discussed by phone message to Dr. Scott by LP and emailed to Ms. Scott on August 7, 2020.

As a surgeon, I was willing to accept some possibility that the implants were a factor but unwilling to take full responsibility in the complication when the likely cause for the bone fracturing and surgical failure was the dog's jumping from vehicle. This is supported due to the fact that none of the implants loosened, broke or were displaced, the implants were intact and doing their job but no matter the number or type of implants selected can overcome allowing a dog to jump from 3-4 feet when minimal bone healing has progressed at 19 days postoperatively.

Around the time of closing on August 10, 2020 we received additional email communication from Ms. Scott requesting an additional $833.00 procedural discount; however this had already been discounted 50% previously. Ms. Scott also indicated that they would be taking the case to the AZBVME if the discount was not applied. SVSS management discussed the case and allowed the additional 50% discount as a courtesy to the owners which would have made the procedure fee $0. We emailed the updated estimate and some discussion of postoperative requirements Ms. Scott on August 13, 2020. So, in sum, it took 7 days (5 business days) for SVSS to provide the required final estimate to the owners. The reason I provided some additional discussion is because I had my own reservations about doing another surgery on Tucker if the owners were going to continue to be non-compliant. Also, it should be noted that the offered discounts would apply if any of my SVSS colleagues had performed the second surgery since the owners were now apparently unhappy with me. We received final communication from Ms. Scott on August 24, 2020 that they were pursuing surgery with another facility. This was our last communication with the Scott family.

In closing, I stand behind the veterinary care we provided for Tucker and honestly feel that the post-operative complication that caused the Scotts to file this Board Complaint would not have occurred had the owners restricted Tucker's activities, followed the aftercare instructions and not allowed Tucker to jump out their SUV shortly after the surgery.

Thank you.

Megan Schaible, DVM, DACVS-SA

DOUGLAS A. DUCEY
- GOVERNOR -

VICTORIA WHITMORE
- EXECUTIVE DIRECTOR -

ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD
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INVESTIGATIVE COMMITTEE REPORT

TO: Arizona State Veterinary Medical Examining Board

FROM: AM Investigative Committee: Robert Kritsberg, DVM - Chair
Christina Tran, DVM
Carolyn Ratajack
Jarrod Butler, DVM
Steven Seiler

STAFF PRESENT: Tracy A. Riendeau, CVT – Investigations
Marc Harris, Assistant Attorney General

RE: Case: 21-16
Complainant(s): Cheryl Scott
Respondent(s): Megan Schaible, DVM (License: 4678)

SUMMARY:
Complaint Received at Board Office: 8/24/20
Committee Discussion: 1/5/21
Board IIR: 2/17/21

APPLICABLE STATUTES AND RULES:
Laws as Amended August 2018 (Lime Green); Rules as Revised September 2013 (Yellow).

On June 11, 2020, "Tucker," a 1½-year-old Shepherd mix was presented to Respondent for a surgical consultation due to a ruptured cranial cruciate ligament on the right limb. Due to the excessive tibial plateau angle, Respondent recommended a TPLO/CCWO; Complainant approved. Surgery was performed that day and the dog was discharged the following day with strict exercise restrictions and rehabilitation instructions.

On June 29, 2020, Complainant reported that the dog had jumped out of their SUV, approximately 3 – 4 feet.

On August 6, 2020, the dog was presented to Respondent for a recheck and revealed the second plate proximal screw holds were not in the bone and reduction of the proximal tibial segment had been lost; revision surgery was recommended.

On August 21, 2020, the dog was presented to Dr. Lirtzman for a second opinion. After reviewing the history and evaluating the dog, it was his opinion that the TPLO/CCWO technique and bone stabilization was inadequate.

Complainant was noticed and appeared telephonically.
Respondent was noticed and appeared telephonically. Attorney, David Stoll appeared.

The Committee reviewed medical records, testimony, and other documentation as described below:

- Complainant(s) narrative: *Cheryl Scott*
- Respondent(s) narrative/medical record: *Megan M. Schaible, DVM*
- Consulting veterinarian(s) narrative/medical record: *Ross Lirtzman, DVM – Arizona Canine Orthopedic & Sports Medicine.*

PROPOSED 'FINDINGS of FACT':

1. On June 11, 2020, the dog was presented to Respondent on referral for surgical consultation. Cranial cruciate ligament rupture on the right leg was confirmed by the primary care veterinarian on October 1, 2019. On June 6, 2020, the dog was seen by the primary care veterinarian for persistent right hindlimb lameness and additional confirmation of the diagnosis.

2. Due to COVID-19, curbside services were being conducted.

3. Technical staff checked the dog in and brought the dog into the premises for Respondent to evaluate. Respondent reviewed the dog's history and radiographs by primary care veterinarian prior to examining the dog (W = 74.6 pounds; T = 102.8; P = 126bpm; R = 30rpm; BCS = 7/9; BAR). She noted right hind limb lameness with right cranial drawer and tibial thrust - the left stifle had mild drawer movement. Respondent's assessment was right cranial cruciate ligament injury, mild tibia thrust/drawer and excessive tibial plateau angle (TPA).

4. Respondent phoned Complainant to discuss her findings and recommendations. She explained that the dog had cranial cruciate ligament disease bilaterally and an abnormal proximal tibia leading to a tibial plateau angle in excess of 35 degrees. Since patients with an excessive TPA do not obtain enough leveling from a standard TPLO and require additional planning, mathematical calculations and surgical procedures. Respondent explained that a cranial closing wedge osteotomy (CCWO), which requires two additional osteotomies, would be necessary in addition to the standard TPLO. She explained the procedures in detail to Complainant stating that detailed decisions would be made during radiographic planning and time of surgery. Respondent placed importance on strict postoperative exercise restrictions – three months with no running, jumping, or stairs and leash at all times until radiographic healing was confirmed – a handout was provided to Complainant. Additionally, Respondent went over the potential complications and the increased risk due to the additional procedures required for the dog. An estimate was provided and approved by Complainant – surgical consent was obtained and the dog was admitted.

5. Blood work and radiographs were performed. Blood work was within normal limits except for a mild increase in cholesterol and low amylase. Radiographs revealed confirmed stifle effusion of the right limb with cranial displacement of the tibia in relation to the femoral condyles and a TPA of 51 degrees. Respondent calculated the degrees and wedge with for the osteotomies.

6. An IV catheter was placed, fluids were started and the dog was pre-medicated. The dog was

induced, intubated and maintained on isoflurane and oxygen; an epidural was provided. The surgical procedures were performed: Right medical stifle arthrotomy; Right TPLO; Right CCWO; Medial meniscal release; and Nocita administration. The dog recovered uneventfully. Respondent contacted Complainant later that day to give a post-operative update on the dog. She went over the procedure and reiterated that these patients have a higher risk of complications due to the multiple bone cuts and that the exercise restriction and rehabilitation instructions were very important to follow.

7. The next morning, the dog was evaluated by an associate and approved for discharge. Technical staff discharged the dog and provided detailed discharge instructions.

8. On June 26, 2020, Complainant stated that the dog jumped out of their stopped SUV after returning home from a weekend trip; the height was approximately 3 – 4 feet. The dog continued to bear weight bilaterally but Complainant still contacted Respondent's premises the next business day. According to Complainant, she explained what transpired and requested radiographs to confirm there was no damage to the implants. She was told that if the dog was still weight bearing, there were no concerns – continue with pain medication, and if the dog stops putting weight on the limb, bring him in.

9. On June 29, 2020, according to Respondent, Complainant called and spoke with a receptionist regarding the dog limping intermittently on the right hindlimb after jumping 3 – 4 feet out of their SUV. Technical staff was given the information and advised Complainant that since an acute event had occurred, the pet owner could consider continuing pain medications and monitor; if the lameness did not resolve, worsens, or persisted intermittently, the dog should be evaluated. Additional pain medication was requested and approved.

10. Complainant stated in her complaint that the dog continued to heal and never had any episodes of non-weight bearing or increased limping for the next 4 weeks.

11. On August 6, 2020, the dog was presented to Respondent for post-operative radiographs. Complainant reported that the dog was still limping off and on and she did not feel the dog was improving as she had thought – they had been limiting the dog's activity but the dog did go up and down stairs last week. Respondent examined the dog (T = 101.3; P = 120bpm; R = panting); she noted the dog had severe muscle atrophy on the right hind limb, grade II/IV lameness and mild pain on palpation. Radiographs were performed and confirmed a complication. They showed progressive bridging on the TPLO osteotomy site with very little elevation of the third proximal screw head. There was no fractured or broken implant. The three screws of the 2.0mm plate were no longer holding in the tibial tuberosity segment and the proximal tibia had lost reduction of the corrective tibial wedge site. The TPA was 41 degrees.

12. Complainant discussed her findings with Complainant and recommended that the complications be addressed surgically. However, they would like to allow the TPLO osteotomy to heal another 4 – 5 weeks prior to revisional surgery. The plan would likely be to remove all implants, perform another osteotomy of the tibial to allow reduction and stabilization with a new plate, pins and tension band system.

13. Respondent discussed that Complainant had not been doing the rehabilitation exercises or the on-leash walk regimen. Complainant explained that her and her husband both work and felt the dog was getting enough exercise since they allow the dog off leash – the dog was supervised and there was no running/jumping. Respondent reminded Complainant that the dog was not supposed to be off leash until approved by the surgeon and that the jump from the vehicle, along with the off-leash activity, could be the cause of the complication.

14. Complainant took pictures of the radiographs and sent them to her husband. After reviewing the radiographs, Complainant asked if Respondent could answer some of her husband's questions – Respondent stated that she could discuss the case with her husband after her scheduled appointments. Complainant stated she would wait and stated she waited for 5 hours. However, Respondent stated that she did speak with Complainant's husband; a revised discounted estimate was provided to Complainant, and Complainant left the premises after being there for approximately 3 hours.

15. Respondent's premises, Complainant, and her husband, were negotiating the cost of the recommended revision surgery.

16. On August 21, 2020, the dog was presented to Dr. Lirtzman at Arizona Canine Orthopedic & Sports Medicine for a second opinion. After reviewing Respondent's medical records, obtaining information from Complainant and examining the dog, Dr. Lirtzman recommended surgery as soon as possible to remove all current right tibial implants, debride non-union osteotomies, and revise the procedure.

17. On August 27, 2020, the dog was presented to Dr. Lirtzman for cranial cruciate injury revision surgery of the right limb.

18. Dr. Lirtzman stated that it was his opinion that the tibial bone fixation that Respondent performed on the dog was inadequate; a detailed explanation can be found in his narrative.

COMMITTEE DISCUSSION:

The Committee discussed that with orthopedic surgery things can easily go awry. In this case, the procedure that was performed was appropriate according to the literature. There are chances for complications to occur. The dog jumping out of the SUV may have had some bearing on the surgical site not healing properly. The discharge instructions were not followed properly; the dog was also off leash and there was another dog in the household.

COMMITTEE'S PROPOSED CONCLUSIONS of LAW:

The Committee concluded that no violations of the *Veterinary Practice Act* occurred.

COMMITTEE'S RECOMMENDED DISPOSITION:

Motion: It was moved and seconded the Board:

Dismiss this issue with no violation.

Vote: The motion was approved with a vote of 5 to 0.

The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.

TR

Tracy A. Riendeau, CVT
Investigative Division